STATE CHILDREN'S HEALTH INSURANCE PROGRAM:
APPLICATION FOR SECTION 1115 DEMONSTRATION PROPOSAL

Date: November 15, 2001; Revised December 12, 2001

Signature and Title of Agency Official:

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Project Title: A Demonstration of the Effectiveness of Maryland's Crowd Out Provision

Proposed Effective Date: August 24, 2001

SECTION 1. RELEVANT CRITERIA

1.1 Provide the implementation date of the State's initial SCHIP plan. (Must be at least one year prior to the date of this application.)
The Maryland Children's Health Program was implemented July 1, 1998.

1.2 The upper income standard for all SCHIP-eligible children through age 18 is currently 300 percent of the Federal Poverty Level (FPL). Specify if the income standard is gross or net and if net, specify those disregards that apply.

This waiver application applies to the first phase of our program which was a Medicaid expansion extending coverage to children through 200 percent of the FPL. Health and Human Services had previously approved our application with a six month waiting period. We are requesting a waiver to allow us to continue that policy.

The income standard is net. Disregards include: Earned and unearned income less $90 monthly earned income disregard; actual self-employment expenses; actual alimony payments; actual child care expenses, not to exceed $175/month per child ($200 per month per child if under age 2); $50 of child support received; and actual student earnings for a full-time student employed full time or part-time or a part-time student who is not employed full-time.

1.3 √☐ The SCHIP is implemented statewide.

1.4 √☐ The SCHIP does not have a waiting list and has not otherwise closed enrollment.

1.5 For those demonstrations that propose to cover populations other than targeted low-income children, the State must show that it has adopted at least three of the following Policies and procedures in both of its child health programs (SCHIP and Medicaid). Check all that apply:

1.51. √ ☐ Check here if this section does not apply. (The demonstration focuses on ways to find and enroll targeted low-income children and does not seek to cover populations other than targeted low-income children.)

1.5.2 ☐ Use of joint application and common application procedure for SCHIP and Medicaid. Please describe the procedure.

1.5.3 ☐ No assets test for SCHIP and Medicaid.

1.5.4 ☐ 12-month continuous eligibility for SCHIP and Medicaid.

1.5.5 ☐ Procedures that simplify and coordinate the redetermination/coverage renewal process. Such procedures allow families to establish their child's continuing

eligibility to be application describe the by mail and, in States with separate child health programs, permit children transferred between Medicaid and the separate program without a new or a gap in coverage when their eligibility status changes. Please procedures.

1.5.6 ☐ Presumptive eligibility for children in Medicaid and presumptive eligibility or provisional enrollment in SCHIP. Describe how the State has implemented

presumptive eligibility or provisional enrollment in SCHIP or, if the State has adopted

other procedures to accelerate children's receipt of covered services under SCHIP, describe these other procedures.

SECTION 2. CURRENTLY APPROVED SCHIP PLAN

2.1 The State uses funds provided under Title XXI for (check appropriate box):
☐ Separate child health program
☐ Medicaid expansion program
√ ☐ Combination program

2.2 Describe the areas of the existing program that will be affected by the demonstration.
The demonstration will not change the existing program, since current efforts will be maintained. Additional data processing and analysis will be required for the evaluation.

2.3 Provide the upper income standards for children enrolled in the Medicaid program (title XIX) and SCHIP. If you propose to cover groups that are not currently covered under title XXI, please include information on current Medicaid coverage of these groups as well. After each standard, indicate with an (n) or (G) whether the State uses a net or gross income test.

Age Group	Medicaid program-highest applicable category (regular match rate)	SCHIP-funded Medicaid expansion program	Separate child health program
Under 1	185% n	200% n	300% n
1 thru 5	133% n	200% n	300% n
6 and older	100% n	200% n	300% n

SECTION 3. DEMONSTRATION PROPOSAL REQUEST

3.1 Demonstration Objective(s) and Evaluation

3.1.1 Provide the research hypothesis or hypotheses for the demonstration.

The Maryland Department of Health and Mental Hygiene seeks, with this waiver, to demonstrate that a six month waiting period for potential MCHP enrollees will prevent crowd out by individuals with private insurance (employer sponsored). The research hypotheses are:

- Hypothesis One: The Maryland crowd out provision prevents those who already have private health insurance from being eligible for public health insurance coverage under MCHP, and discourages those who currently have private health insurance from substituting public for private insurance.

- Hypothesis Two: The Maryland crowd out provision does not result in increased medical expenses during the initial months of enrollment prior to assignment to an MCO.

The rationale for each hypothesis follows.

BACKGROUND
The Maryland Children's Health Program (MCHP) currently includes a provision to address concerns regarding the need to safeguard the private market from crowd out. Crowd out is broadly defined as the substitution of public health insurance coverage for private health insurance coverage. Maryland's approach to preventing crowd out includes several strategies: a waiting period, whereby potential enrollees must be uninsured for six months before being permitted to enroll in MCHP; monitoring of application questions regarding children's health insurance status; and verification of insurance status against databases of private coverage.

Maryland's crowd out provision requires a six month waiting period for applicants that have employer-sponsored insurance or have voluntarily terminated employer based coverage within six months of application. MCHP expanded Medicaid eligibility to 200 percent FPL. Nationally, there is little evidence (Lutzky and Hill, 2001) of crowd out below 150 percent of the FPL, but there is an increased risk of crowd out with higher income eligibility levels. The Health Care Financing Administration (now CMS) proposed rules (Federal Register, 1999) required states that provide coverage to children in families above 200 percent FPL to implement specific procedures or strategies to limit substitution. This waiver proposal applies to "targeted low-income children" and "optional targeted low-income children" up to 200 percent FPL (see description of the demonstration population on page 7).

HYPOTHESIS ONE: The Maryland crowd out provision prevents those who already have private health insurance from being eligible for public health insurance coverage under MCHP,

and discourages those who currently have private health insurance from substituting public for private insurance.

Private market crowd out results from the behavior of either consumers, employers, or a combination of the two. Specifically, public insurance crowds out private coverage when individuals choose a government-subsidized program instead of selecting or keeping available employer-sponsored coverage (Lutzky and Hill). This may occur either when 1) a family actively drops private dependent coverage to enroll their child in subsidized health coverage, (sometimes called "opt-out") or 2) when a previously uninsured family whose child is enrolled in MCHP chooses to maintain that coverage and refuses an offer of employer-sponsored insurance (Robert Wood Johnson, 2001). Crowd out may also occur 3) when an employer deliberately reduces or eliminates health insurance coverage for workers and their dependents with the expectation that available public programs instead will provide needed coverage. Crowd out can also occur when 4) an employer ceases to offer group coverage, or raises cost-sharing to unaffordable levels knowing their employees may be eligible for public coverage (sometimes called "push-out") (Robert Wood Johnson, 2001). Finally, crowd out may occur 5) as a result of a combination of employer and individual actions: if an employer covers only a small portion of the cost of insurance, the remainder is then transmitted to families through premiums and cost sharing, which families may perceive as unaffordable and decide not to purchase (Health Affairs, 1998).

The rising costs of health insurance to employers and their employees increase the risk of crowd out. A study by the Health Insurance Association of America (December, 2000) found that the primary reason for the increase in the number of Americans without health insurance over the past 15 years is the increase of health care costs relative to family income. As these costs increase, families decrease their purchase of health care services, especially health insurance.

Health insurance premiums are expected to surge at double-digit rates in 2002 (USA Today, 8/27/01). This may force employers and employees to make tough and costly choices. Due to dramatic increases in drugs and hospital care, insurers are seeking premium increases from 13 percent to 50 percent-the highest in a decade. Such dramatic increases make it extremely difficult for employers to provide health benefits. In addition to increased premiums, tight restrictions, including exclusions for preexisting conditions and waiting periods, keep many workers from enrolling in employer-sponsored plans. Furthermore, in small firms, most workers have access to only one plan and the absence of choice may discourage enrollment. Workers are also affected by a falling economy, failing corporate profit, and rising layoffs. It is increasingly common for employers to be forced to pass along the rising costs to their employees.

Displacement of private coverage may occur in less obvious ways than when employers or families drop existing coverage in order to gain a subsidy. Over time, labor markets are likely to adapt to the presence of federal subsidies. New low wage firms, for instance, may choose not to

offer family coverage if subsidized coverage for children is available. Or low-wage workers may seek jobs in firms that offer higher wages in lieu of insurance. About 52 percent of employees in low-wage firms (where 35 percent or more of the workers earn less than $20,000 per year) are

covered through their own employer, compared with 69 percent of workers in high-wage firms (where less than 35 percent of the workers earn less than $20,000 per year). Higher coverage rates in high-wage firms that offer health benefits are a function of both higher eligibility rates and higher take-up rates. (The Kaiser Foundation, 2000). As the labor market adjusts to these changes, crowd out (substitution) is inevitable. Efforts to monitor crowd out and minimize its effects on eroding public access to health insurance are necessary.

The magnitude of crowd out depends on the income eligibility level of the program, the success of attempts to minimize substitution of public coverage for private coverage, and the generosity of the benefit package under the SCHIP program relative to employer-sponsored coverage. Several states have demonstrated that crowd out exists among SCHIP enrollees. For example, Rhode Island, which has retained a crowd out provision for enrollees above 110 percent FPL in its RiteCare and RiteShare programs, has declared its crowd out rate to be nine percent among eight to 19 year old enrollees between 100 and 185 percent FPL.

Using data from the Current Population Survey (CPS) and targeting the analysis on poor and near poor pregnant women and children ages 10 and under, Dubay and Kenney (1997) found that among children ages 10 and under, there was a 17 percent increase in enrollment of young children attributable to crowd out. These estimates represent the degree to which public funds substituted for private funds over the period. No evidence was found, however, for crowding out for the poor (below the poverty line) children. For pregnant women with household income above the poverty line (100-185 percent of poverty) they found the crowd out effect to be 45 percent. Among children with household incomes above the poverty line (that is, 100-133 percent of poverty for children) they found a crowd out effect to be 21 percent.

The data suggests more crowding out occurs as income eligibility thresholds increase. This is because as income increases, the prevalence of employer-sponsored coverage increases and the proportion of households without insurance decreases. Therefore, even if only a small percentage of families substitute public for private coverage in MCHP, as the income eligibility cutoff for a new program increases, the percentage of entrants into that program will increasingly come from those who previously had private coverage. Programs offering coverage to children at higher income levels could potentially see a larger share of public dollars replacing employer and individual contributions than programs limiting coverage to lower income groups. In an era of scarce resources, it is important to reduce the incentives to substitute public for private dollars.

HYPOTHESIS TWO: The Maryland crowd out provision does not result in increased medical expenses during the initial months of enrollment prior to assignment to an MCO.

Absent any good studies which examine this issue, it is not possible to know how people behave during waiting periods. Do they delay obtaining care, thereby enrolling with poorer health status than they had when first applying? Do they rely on public safety-net services to receive care, thereby costing the state more money than if they had enrolled when first applying? (Robert Wood Johnson Foundation, 2001). There has been no previous study of Maryland MCHP applicants to determine if this factor warrants dropping the six month waiting period but there is evidence (Lave, et. al., 1998) that parents of uninsured children reduce the children's physical risks and

therefore the likelihood of need for medical care, rather than delaying care. This demonstration seeks to verify this assumption.

3.1.2 Identify the demonstration objective(s).

The objectives of this demonstration are:

- Objective 1. To demonstrate the effectiveness of crowd out provisions among potential MCHP enrollees below 200 percent FPL in discouraging those who already have health insurance from dropping their insurance to become eligible for public health insurance, and

- Objective 2. To demonstrate that fears of pent up demand for medical care as a result of crowd out provisions are unwarranted.

The goal of these efforts is to ensure that uninsured children become insured, while maximizing the efficiency of public funding targeted to children without access to insurance.

3.1.3 Specify the research design and identify the population(s) that will be compared to the demonstration population.

The State of Maryland will utilize a prospective study design to investigate the experiences of MCHP applicants with regard to the six-month waiting period. Ideally, our study design would include exploration of privately insured children throughout the state to determine whether they do or do not drop employer based insurance to apply for MCHP; however, such a comprehensive investigation is beyond the scope of this demonstration.

The demonstration population for both Objectives 1 and 2 consists of "targeted low-income children" and "optional targeted low-income children":

- children under age one with incomes between 185 and 200 percent of the FPL,
- children ages one through five between 133 and 200 percent of the FPL, and
- children ages six and older between 100 and 200 percent of the FPL.

Because we lack a comparison population that is sufficiently similar to the demonstration population, study of Objective 1 will focus primarily on the behavior of MCHP applicants, and comparison between populations will be studied only as a secondary question. The comparison population for Objective 1, where needed, consists of traditional Medicaid applicants (children only):

- children under age one, with incomes below 185 percent of the FPL,
- children ages one through five below 133 percent of FPL, and
- children ages six and older below 100 percent of the FPL.

Enrollment among the traditional Medicaid population is not contingent upon a waiting period, regardless of the insurance status of the enrollee prior to Medicaid participation.

The comparison population for Objective 2 consists of MCHP enrollees who did not have private insurance prior to application and therefore were not required to wait six months prior to enrollment.

The demonstration population and both comparison populations will consist of enrollees in MCHP and Medicaid based on the truncated eligibility schedule that appears earlier in Section 2.3.

Whether the crowd out provision affects enrollment of applicants, as well as utilization behavior in the months immediately following enrollment, will be determined. All applicants to MCHP and Medicaid will be examined according to the variables described in section 3.1.5. Data will be collected from available and existing state databases and will be analyzed utilizing either the Statistical Package for Social Sciences (SPSS) or SAS.

Analyses will be conducted on an annual basis, culminating in a cumulative analysis at the conclusion of the five-year demonstration period. Additional reporting will be conducted for CMS based on federal requirements. An analysis will be conducted to include the first two years of data. If at that point, there is little or no evidence of crowd out, we intend to approach the legislature and governor to enact legislation removing the crowd out provision requirements from state law.

Determining the impact of an intervention requires comparing groups whose major difference is whether or not they have experienced the intervention. Study designs that do not utilize a strong comparison population are limited in validity because it is difficult to know whether the observed results are due to the intervention itself, or to other causes. Still, because we intend to collect comprehensive data on the study population for Objective 1 and will research national crowd out trends, we will be able to make strong assumptions about the effectiveness of our crowd out provision. Also, comparison between applicants with higher and lower incomes exposes several limitations to the study. First, traditional Medicaid children are lower-income and less likely to be insured, and therefore, less likely to engage in crowd out. However, because some of the comparison group have incomes above 100 and 150 percent of the FPL, where crowd out is believed to increase, we anticipate that a valid comparison indeed may be made. Furthermore, we have decided to consider any comparison of the two populations secondary to the study of the demonstration population itself. Second, because poorer health status is correlated with lower income levels, the traditional Medicaid applicants may have a greater need for health services than the demonstration population, confounding our analysis of pent up demand. However, the lack of a waiting period among this group provides a good control when analyzing pent up demand, even if health services may be inflated due to lower income levels.

3.1.4 Identify the data sources for the evaluation.

The information to be collected for this evaluation is available from several sources. Maryland Medicaid application data to be used to analyze variables pertaining to Objective 1 are included in the Client Automated Resource Eligibility System (CARES). This system is maintained by the Maryland Department of Human Resources (DHR). At the time of application, demographic information is collected, along with citizenship, income and assets information. Maryland recently

revised the MCHP application to capture detailed information about current insurance status, past insurance coverage and reasons for dropping insurance. Applicants certify that the information included in the application is true and correct. In addition, independent verification of the insurance information is available since Maryland subcontracts with Health Management Systems, Inc. (HMS) for cross-checks with existing insurance data bases.

For variables pertaining to Objective 2, medical claims data are contained in the MMIS II claims processing files. Claims data will provide valuable information about the existence of theorized pent up demand among applicants held to a waiting period for coverage. MCHP clients are potentially eligible for Maryland's managed care program "HealthChoice", but fee-for-service data does exist for those who are excluded or do not participate. Claims data and other administrative data provide an "audit trail" of the health care process. Although mainly used for bill paying and monitoring expenditures, claims data also chronicle health care events. They offer an array of information including diagnosis, type and number of ambulatory encounters, types of diagnostic tests and surgical and other therapeutic procedures performed, type of prescription filled, and duration and level of hospitalization. Linking of claims data to beneficiary files allows identification of the demographic characteristics of the insured persons.

Claims data have several advantages over primary data (data collected solely for a particular study). First, they are inexpensive to obtain. They are also unobtrusive, since cooperation with the recipient is not needed, and therefore also allow for unbiased data collection. Utilization of Maryland claims data for analytic and reporting purposes is possible. Maryland is and historically has been involved in major research studies due to the availability and quality of the Medicaid claims files. Considerable experience has been gained in aggregating and analyzing data to show trends over time and relationships among types of services and eligibility categories. Maryland MCHP data is processed with traditional Medicaid claims and therefore can be expected to be compatible and of the same high quality.

3.1.5 Describe the State's plan for data analysis.

To determine the success of the crowd out provision in meeting Objectives 1 and 2, several variables will be examined, shown in the table below.

OBJECTIVE	MEASURE	VARIABLE(S)	STUDY POPULATION	COMPARISON POPULATION
1.	Applicants applying to MCHP/Medicaid, privately insured within	Number and proportion of applicants with private insurance within 6 months	MCHP applicants (see list on page 7)	Traditional Medicaid applicants (comparison between

	6 months.	of application.		populations represents secondary issue) (see list on page 7)
1.	Applicants applying to MCHP/Medicaid, privately insured more than 6 months prior to application.	Number and proportion of applicants with private insurance more than 6 months prior to application.	Same	Same
1.	Employer behavior.	Number of applicants with private coverage within 6 months indicating that employer dropped coverage.	Same	Same
1.	Employee behavior.	• Number of applicants with private coverage within 6 months that voluntarily dropped coverage. • Numbers and proportions of applicants with private insurance within 6 months who were exempted from the crowd out provision, by reason for exemption.	Same	Same
2.	Extent of medical care in the initial months of enrollment prior to assignment to an MCO.	• Number of medical visits • Total medical costs for all enrollees • Average medical costs per enrollee	MCHP enrollees (see list on page 7) required to wait six months prior to enrollment	MCHP enrollees (see list on page 7) not required to wait six months prior to enrollment

The effectiveness of the crowd out provision in discouraging potential applicants from dropping private coverage will be measured by several variables. First, we will determine the number and proportion of applicants who indicate private coverage within six months of applying to MCHP. To add depth to the study of MCHP applicants, we will also study the number and proportion of Medicaid applicants with private insurance within 6 months and one year prior to submitting an application. We recognize the limitations of using this group as a comparison group (see above).

In all cases, applicant accounts of insurance status will be verified to identify cases where insurance status is uncertain, or deliberate attempts to conceal insurance status have been made. We will use the appropriate between-subject tests (x^2, and t tests) to assess statistical significance**.**

Second, reasons for loss of coverage also will be explored to determine what proportions of crowd out are motivated by employers or employees voluntarily dropping coverage. Because not all MCHP applicants with private insurance within six months of application are denied

eligibility, numbers and proportions of applicants exempted from the crowd out provision also will be studied. Exempted individuals include those who drop insurance due to

- a change in employer,
- moving out of an insurer's service area,
- involuntary loss of employment,
- expiration of COBRA coverage period, and
- a limited benefit insurance that didn't include inpatient hospital coverage.

Affordability of private coverage for families will be examined for an understanding of employee behavior.

Because some applicants can be expected to be aware of the provision and therefore delay application for six months, denials of enrollment due to insurance coverage are not likely to provide the total picture of potential crowd out in Maryland. However, number and proportion of applicants whose private coverage was dropped more than six months ago will also be collected and analyzed, providing a more complete indicator of the extent of crowd out.

To disprove that pent up demand and increased medical costs result from waiting periods, extent of medical care within the initial months of enrollment prior to assignment to an MCO among the demonstration and comparison groups will be examined. Number of medical visits, total medical costs for all enrollees and average medical costs per enrollee will be compared to determine if a significant difference exits between the groups. Where warranted, logistic regression will be utilized.

Collecting utilization data from the first months of MCHP enrollment may limit our ability to capture the full extent of pent up medical use among children required to wait to enroll in MCHP because of potential delays in scheduling physician appointments. However, information gathered in formal focus groups conducted as part of Maryland's evaluation of its MCHP and Medicaid managed care program indicate that enrollees typically are able to secure health care services within several weeks of calling to make appointments.
All measures will be tracked throughout the five-year demonstration to determine if trends change over time. Additional analysis of denied children will be conducted to determine the extent that reapplication occurs and if it results in acceptance or denial from MCHP eligibility.

Eligibility data and insurance verification information will be collected on a monthly basis over the term of the demonstration. Claims information will be obtained on an annual basis. The extent of medical care will be examined through a comparison of the average number of physician visits and total claims. If warranted, logistic regression will be used to assess the impact of various predictors on the odds that a child would use health care services. The children will be subdivided into those who were subjected to a six month waiting period and those who were not. Health care
encounters will be defined as at least one current procedural terminology code during the initial months after enrollment prior to assignment to an MCO. Predictor variables such as age at enrollment, sex, race and ethnicity will be included.

3. 1.6 Identify who will have oversight for the evaluation and who will perform each component of the evaluation.

Oversight of the demonstration will rest with the Maryland Children's Health Program Division as part of overall management of MCHP.

3.2 Public Process

3.2.1 Public notice requirements must be satisfied by one or more of the following processes (as required by Federal Register Notice published September 27, 1994). Check all that Apply and include a brief description.

☐ Public hearings, at which the most recent working proposal is described and made available to the public, and time is provided during which comments can be received.

☐ Commission or similar process where meetings are open to the public, in the development of the proposal.

☐ Enactment of a proposal by the State legislature prior to submission of the demonstration proposal, where the outline of such proposal is contained in the legislative enactment.

☐ Formal notice and comment in accordance with the State's administrative procedure Act, provided that such notice must be given at least 30 days prior to submission.

☐ Notice of the intent to submit a demonstration proposal in newspapers of general circulation, and mailing of notices to groups within the State that are likely to be interested in and to comment on the proposal. This notice shall include an opportunity, which shall not be less than 30 days, to comment on the proposal.

√ ☐ Any other similar process for public input that would afford an interested party the opportunity to learn about the contents of the proposal, and to comment on its contents.

The state legislature initially included crowd out provisions because they strongly felt the provisions were necessary for the success of the program. MCHP's high enrollment (currently over 90,000 children) attests to their judgement. In its application to the Health Care Financing Administration for the original MCHP in April 1998, which incorporated the crowd out provision we are attempting to preserve with this waiver, the State engaged in an extensive public process to obtain input on the program's design and implementation. This process included four public hearings throughout the State, a Governor's Round Table on Children's Health Insurance, and four regional briefings, and provided all stakeholders with ample opportunity to comment on the crowd out provision.

For the purposes of this application, the State informed a wide variety of stakeholders of the waiver on September 20 at the monthly Maryland Medicaid Advisory Committee, a group including members from the public and public interest groups.

In addition, on October 26, the waiver proposal was circulated by email to an existing list of advocacy groups and other stakeholders to facilitate quick review and comment. Individuals receiving the email were given 2 full weeks, until November 12, to read and comment on the proposal. The State of Maryland received several comments, conducted conference calls with several interested parties, and incorporated a number of changes accordingly prior to submission of the application to CMS on November 16, 2001.

3.2.2 Provide a description of the process to confer with Federally recognized Tribes, including A description of any issues and concerns raised by the Tribes regarding the proposal. Maryland has no Federally recognized Tribes, therefore this section is not applicable.

3.2.3 Describe any efforts by the State to seek input from public interest groups in addition to those noted in section 3.2.1. Include any evidence of broad support and a discussion of any major concerns about the demonstration.

3.3 Budget

3.3.1 Provide budget information for the approved SCHIP State plan and for the proposed demonstration by completing the budget template on the following page. The budget must include the following:

3.3.1.1. Expenditures for the past fiscal year for the approved SCHIP State plan. See attached budget template.

3.3.1.2 A five year budget projection for the approved SCHIP State plan. See attached budget template

3.3.1.3 A five year budget projection for the SCHIP that assumes that the demonstration is approved. Separate the costs associated with the demonstration from the costs associated with the approved State plan. See attached budget template

3.3.2 Explain how the State will track the expenses of the demonstration separately from those in the approved State plan.
Because the demonstration seeks to maintain the approved State plan exactly as it currently exists, and because the demonstration population consists of the current and future SCHIP population, the state will track expenditures using the same methodology it currently utilizes, primarily through MMIS.

3.3.3 Specify the source of the non-Federal share of funds for the demonstration and Identify funds for which the State will claim enhanced Federal match.

State general funds will be the source of non-federal funds.

3.4 Program Administration

3.4.1 Describe the organizational structure for administering the demonstration.
We will review the voluntary dropping of insurance through the automated eligibility determination process, the MMIS II system and insurance verification procedures based on regulations and policy and developed and overseen by the Maryland Children's Health Program (MCHP) Division as part of overall management of MCHP.

3.4.2 Describe how administration of the demonstration will be coordinated with the SCHIP and/or Medicaid programs.
The Maryland Children's Health Program Division will oversee the demonstration and is an extension of the Maryland Medicaid program.

3.4.3 If applicable, describe how will the demonstration will impact other child health programs in the State.
Not applicable, no impact foreseen.

3.4.4 Explain whether implementation of the demonstration requires legislative action by the State. If so, indicate the likelihood of receiving legislative authority and the time frame.
Implementation will not require legislative action.

3.5 Specific Program Design

The State is proposing a demonstration project in the following areas:

☐ Parent/caretaker coverage. Please complete Section 4.
☐ Pregnant women coverage. Please complete Section 5.
☐ Provision of additional benefits or services to children. Please complete Section 6.
√☐ Other. Please include a description of proposal in Section 7.

SECTION 7. Other
Complete this section if the State's proposed demonstration is not described in Section 4, 5 or 6.

Provide specific details of the proposed demonstration project, including a description of the population that will benefit from the project and how the project will be implemented.

Maryland is proposing the demonstration project to maintain a crowd out provision in the Maryland Children's Health Program (MCHP). An evaluation of the benefits of this provision are warranted given the higher income groups included in the MCHP program, the lack of evidence that these provisions are not necessary to maintain program integrity, the current success in enrollment in MCHP and the need to maximize the efficiency of public funding targeted to children

without access to health insurance.

One of the goals of exploring crowd out is to gain greater insight into how policies and their implementation affect behavior among those with a stake in the policy. In the case of MCHP, stakeholders span the realm from low-income children and families, providers, employers, state public health and Medicaid staff, and the insurance industry. Examination of the information available from current program data may enable state analysts, policy makers and the state legislature to evaluate current policies and design new ones that will reach more of the uninsured.

Design of new strategies can address basic issues of program purpose and evaluate trade-offs. If the program is to continue to increase the numbers of children with health insurance, these factors need to be taken into account when examining substitution rates, so as not to penalize programs that will ultimately improve public health and lower the public health costs.

We propose to examine the behavior of persons who already have health insurance, to determine if current crowd out provisions do discourage them from seeking public health insurance coverage. We also propose to examine the behavior of persons who choose to drop private insurance or opt-out of coverage to become eligible for MCHP. Analysis of the reasons for dropping coverage can help us determine if changes are occurring due to opt-out, push-out or a combination of these factors. Appropriate strategies can then be developed to address the underlying causes for dropping insurance coverage.

An examination of behavior during waiting periods is necessary to fully understand the implications of a waiting period to discourage crowd out. Do parents delay obtaining care, thereby enrolling their children with poorer health status than they had when they first applied? Do they cost the state more money as a result of pent up demand or costly treatment of advanced illnesses?

Health insurance premiums are expected to surge at double-digit rates in 2002. Prohibitions on participation for a period of time following an child's dis-enrollment from an employer-sponsored plan could provide a disincentive for low-income workers to drop their current family coverage. How will Maryland's policies aimed at limiting crowd out, both direct and indirect, affect employer behavior? Will employers drop dependent coverage but not alter their employer-sponsored insurance for their employees? Or will they cut benefits from the coverage offered to their employees?

The need to align policy goals with existing political realities does not always make for easy policy making. When it comes to health care and health coverage, the question is how to make insurance coverage accessible and affordable while recognizing the need for equitable and efficient use of public funds. Consequently, defining, researching, and predicting crowd out and its causes become complex yet necessary, exercises in the era of insurance expansions for the un- and underinsured. SCHIP afforded states flexibility and freedom in program development. With this freedom, however, came a responsibility to delve deeper into the question of how implementation of new programs affects existing systems and constituencies.

The demonstration includes no changes to the provision of services, does not change the targeted

population and utilizes existing data bases for ease of analysis. Measuring crowd out or crowd out indicators is possible and can be done relatively inexpensively. By taking the time to examine why individuals and families make insurance transitions, and how employers and the market respond to policy interventions aimed at helping individuals and families, researchers and policy makers can all better understand the needs of our uninsured and how best to meet those needs given inevitable policy, political and financial constraints.

The benefit of the project is to ensure that uninsured children are insured and to maintain the fiscal integrity of the program, without dismantling the private insurance system in the state. Applicants who have insurance will not be eligible, processing time for eligible applicants will be decreased and benefits paid to those currently without health insurance will be facilitated.

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